



## Certification of ADA Paratransit Eligibility

The information obtained in this certification process will be used by the City of Santa Fe for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person/agency.

- ☐ **First Time Applicant**  
☐ **Renewal Applicant - Current Card # \_\_\_\_\_**

1. **Name** \_\_\_\_\_
2. **Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_
- Mailing Address if Different** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_
3. **Telephone Number (Home)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_ **(Work)** \_\_\_\_\_
4. **Date of Birth** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
5. **Which of the following best describes your disability?**

- \_\_\_\_\_ a. The condition I have prevents me from using the fixed route system (Santa Fe Trails Bus Service) permanently.
- \_\_\_\_\_ b. My condition is temporary and I should be able to use the fixed route system (Santa Fe Trails Bus Service) by \_\_\_\_\_ (date).
- \_\_\_\_\_ c. My condition is intermittent \_\_\_\_\_ % of the time and I will not be able to use the fixed route system (Santa Fe Trails Bus Service)

6. **How does this disability prevent you from using fixed route service (Santa Fe Trails Bus Service)? Please explain completely. Use additional sheet if needed.**

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7. **Are there any other effects of your disability of which we need to be aware of?**

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The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by the City of Santa Fe.

**8. Do you use any of the following aids for mobility? (check all that apply)**

<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Cane	<input type="checkbox"/> Service Animal
<input type="checkbox"/> Powered Scooter	<input type="checkbox"/> Walker	<input type="checkbox"/> Personal Care Attendant
<input type="checkbox"/> Electric Wheelchair	<input type="checkbox"/> Crutches	

**9. Do you require a personal Care Attendant when you travel using public transit?**

☐ Yes ☐ No

**10. Please answer all of the following questions:**

**Can you travel one city block without the assistance of another person?**

☐ Yes ☐ No ☐ Sometimes

**Can you travel 5 city blocks without the assistance of another person?**

☐ Yes ☐ No ☐ Sometimes

**Can you climb three 12-inch steps without assistance?**

☐ Yes ☐ No ☐ Sometimes

**Can you wait outside without support for ten minutes?**

☐ Yes ☐ No ☐ Sometimes

**11. I hereby certify that the information given above is correct.**

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**12. Name of Emergency Contact** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**13. If this application has been completed by someone other than the person requesting certification, that person must complete the following:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**RETURN FORM TO: TRANSIT SERVICE  
P.O. BOX 909  
SANTA FE, NM 87504-0909**



## RELEASE OF INFORMATION

In order to allow the City of Santa Fe to evaluate your request, it may be necessary to contact the physician or other licensed professional, to confirm the information they will provide when you submit the following the "Requested for Professional Verification". Please send complete applications only, incomplete applications will not be processed.

The person completing the "Request for Professional Verification" form is: (check one)

\_\_\_\_\_ Physician      \_\_\_\_\_ Health Care Professional  
\_\_\_\_\_ Rehabilitation Professional

This person is familiar with the effects of my disability and is authorized to complete the professional verification for of the City of Santa Fe required to complete this certification process.

Name \_\_\_\_\_  
(Physicians or Professionals Name)

Address \_\_\_\_\_  
(Physicians or Professionals Address)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Applicant Name)



## REQUEST FOR PROFESSIONAL VERIFICATION

**THIS SECTION TO BE COMPLETED BY PHYSICIAN, NURSE OR STATE LICENSED SOCIAL WORKER. ANY ALTERATIONS, DELETIONS OR ADDITIONS BY APPLICANT SHALL MAKE THIS APPLICATION VOID.**

Note: Questions #3 and #6 must be completed to process the application.

Dear \_\_\_\_\_,  
(Physician's Name)

The attached authorization form has been submitted by \_\_\_\_\_  
(Applicant's Name)

has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our fixed route transit service (Santa Fe Trails Bus Service). Federal law requires that the City of Santa Fe provide paratransit services to persons who cannot utilize available bus service (Santa Fe Bus Service). The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter. If you have any questions call (505) 955-2002.

1. Capacity in which you know the applicant:

I am his/her \_\_\_\_\_.  
(patient's name)

2. Which of the following best describes your client's (patient's) disability?

- \_\_\_\_\_ a. The condition is permanent
- \_\_\_\_\_ b. The condition is temporary and he/she should be able to use the fixed route system (Santa Fe Trails Bus Service) by \_\_\_\_\_ (date).
- \_\_\_\_\_ c. The condition is intermittent \_\_\_\_\_ % of the time and he/she will not be able to use the fixed route system (Santa Fe Trails Bus Service).

If you selected c. please explain you answer.

\_\_\_\_\_

3. If the person has a disability affecting mobility, is the person:  
Able to walk one city block without the assistance of another person?  
\_\_\_\_\_ Yes          \_\_\_\_\_ No          \_\_\_\_\_ Sometimes  
Able to travel 5 city blocks without the assistance of another person?  
\_\_\_\_\_ Yes          \_\_\_\_\_ No          \_\_\_\_\_ Sometimes  
Able to climb three 12-inch steps without assistance?  
\_\_\_\_\_ Yes          \_\_\_\_\_ No          \_\_\_\_\_ Sometimes  
Able to wait outside without support for ten minutes?  
\_\_\_\_\_ Yes          \_\_\_\_\_ No          \_\_\_\_\_ Sometimes

Does this person use any mobility aids? If so what?

Does this person require a private care attendant when traveling public transportation (Santa Fe Ride)?

\_\_\_\_\_ Yes          \_\_\_\_\_ No          \_\_\_\_\_ Sometimes

4. If the person has a visual Impairment:

Visual Acuity with Best Correction:

Right eye \_\_\_\_\_ Left eye \_\_\_\_\_ Both Eyes \_\_\_\_\_

Visual fields:

Right eye \_\_\_\_\_ Left eye \_\_\_\_\_ Both Eyes \_\_\_\_\_

Can the person read 12 in font print? \_\_\_\_\_yes          \_\_\_\_\_no

5. If the person has a cognitive disability:

Is the person able to:

Give addresses and telephone number on request?

\_\_\_\_\_ No          \_\_\_\_\_ Yes

Recognize a destination or landmark?

\_\_\_\_\_ No          \_\_\_\_\_ Yes

Deal with unexpected situations or unexpected change in routine?

\_\_\_\_\_ No          \_\_\_\_\_ Yes

Ask for, understand, and follow directions?

\_\_\_\_\_ No          \_\_\_\_\_ Yes

Safely and effectively travel through crowded and/or complex facilities?

\_\_\_\_\_ No \_\_\_\_\_ Yes

6. Please describe below in detail what the disability of your patient is and what prevents them from using the Santa Fe Trails fixed route service. Please indicate if the applicant has a physical or a mental disability, and is there any other effect of the disability of which the City of Santa Fe should be aware?

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Physician Name (Print): \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Physician/Healthcare Professional Signature: \_\_\_\_\_ Date \_\_\_\_\_

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